DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0284	A. BUILDING: _____ B. WING _____	C 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING WILLOW ASSISTED LIVING	601 DAWN AVENUE FREDERICKSBURG, IA 50630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 8 Number of tenants with cognitive impairment: 16 Total census: 24 No regulatory insufficiencies were cited during the investigations of Complaint #118864-C, Complaint #117755-C, and the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program for People with Dementia. The following deficiency was cited during the investigation of Incident #119489-I and Incident #121310-I.	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, staff failed to follow established policies during two separate incidents involving 2 of 6 tenants reviewed (Tenant #1 and Tenant C1). Findings include:	A 150		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0284	A. BUILDING: _____ B. WING _____	C 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING WILLOW ASSISTED LIVING	601 DAWN AVENUE FREDERICKSBURG, IA 50630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 150	Continued From page 1 1. Record review on 7/1/24 revealed Tenant #1 was admitted to the Program 12/29/21. Tenant #1's record included an internal investigation completed by the Regional Nurse Manager on 6/4/24, which documented on 6/4/24 Staff A reported to administration on 5/28/24 she observed Staff B push down on the shoulders of Tenant #1 to keep her on the toilet. Staff A reported she observed Staff B clap her hands loudly and yell in Tenant #1's face to sit down while Tenant #1 was on the toilet. Staff A reported she asked Staff B if she would like a break or some assistance, but she declined. The internal investigation revealed the Community Director reported the allegations of abuse to the Department on 6/5/24 after the internal investigation was complete. Tenant #1's record further noted an assessment was completed and documented in nurse's notes on 6/5/24 by the Regional Nurse Manager. The physical assessment revealed Tenant #1 had a small skin tear and bruise noted on her left forearm. Tenant #1 also had a bruise on the left hand and three small dime sized bruises in a line on her upper right arm. On 6/27/24, the Program's Reportable Events - Adult Abuse Reporting policy was reviewed. The Program's policy revealed the following: Procedure if Abuse Occurrence Occurred in DIAL Environment: a.) If staff suspect a tenant has been abused, staff are required to report the information immediately to the Program's administration or Community Director. When interviewed on 7/1/24 at 11:08 am, the Community Director stated Staff A should have	A 150	A150 Whispering Willow does follow policies and procedures as listed in the policy handbook. 1. The Regional Nurse and Director retrained and reviewed with all staff on the Adult Abuse reporting policy as well as the resident fall policy. Also, all staff were required to redo their Dependent Adult Abuse certification. 2. Upon hire and annually, at a staff in-service, management will review all policies and procedures with the staff members. 3. Management will monitor all policies and procedures documents to make sure everything is signed by staff members with their acknowledgement of the policies and procedures. 4. The Resident Fall policy was reviewed with all staff on 02/14/2024. The Adult Abuse reporting policy was reviewed with all staff on 06/05/2024 and all of the Depended Adult Abuse recertifications were completed on 06/12/2024.	

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0284	A. BUILDING: _____ B. WING _____	C 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING WILLOW ASSISTED LIVING	601 DAWN AVENUE FREDERICKSBURG, IA 50630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 150	Continued From page 2 reported the incident involving Tenant #1 and Staff B immediately to the Community Director or anyone in administration per Program policy. The Community Director confirmed Staff A reported the concerns seven days after the alleged incident. The Community Director stated Staff A was disciplined in the matter and Staff B resigned due to not being able to work during an investigation. 2. Record review on 7/1/24 revealed Tenant C1's record noted an admission date of 10/7/23. Tenant C1's record revealed an incident report dated 1/26/24. The incident report revealed on 1/26/24 at 2:00 am, Tenant C1 was found on the floor beside the bed in her apartment. The report revealed Tenant C1 had a bruised left hip and a rug burn on her left elbow. The incident report indicated two staff members assisted Tenant C1 off the floor into a wheelchair. Tenant C1 was taken to the staff desk and vitals were taken. Staff contacted the on-call nurse, Tenant C1's emergency contact, and 911. When interviewed on 7/9/24 at 11:15 am Staff B stated she completed safety head check rounds on 1/26/24 at around 2:00 am. Staff B stated when she opened Tenant C1's apartment door she discovered her lying on her side on the floor. Tenant C1 appeared to be trying to get up. Staff B stated she called for Staff A to assist her. Staff B stated her and Staff A lifted Tenant C1 from the floor and placed her in her in a wheelchair. Staff B and Staff A pushed Tenant C1 to the staff desk and completed vitals on her. Staff B stated she called the on-call nurse and completed an incident report. Staff B could not recall if Tenant C1 had any bruising or injury. Staff B stated Tenant C1 said "Ow," after she was placed in the wheelchair.	A 150		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0284	A. BUILDING: _____ B. WING _____	C 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING WILLOW ASSISTED LIVING	601 DAWN AVENUE FREDERICKSBURG, IA 50630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 150	Continued From page 3 When interviewed on 7/9/24 at 10:00 am Staff A stated Staff B called her to the memory care on 1/26/24 at 2:00 am. Staff A observed Tenant C1 on the floor. Staff A stated the staff could not get vitals when she was on the floor. Tenant C1 tried to get up. Staff A and Staff B lifted Tenant C1 off the floor and placed her in a wheelchair. Staff A stated they pushed her to the nurse's station and Staff B called the on-call nurse. Staff A stated she did not recall any bruising on Tenant C1. When interviewed on 7/1/24 at 12:46 pm Staff C stated if she discovered a tenant had fallen, she would have called the on-call nurse or hospice for directions prior to assisting the tenant up off the floor. When interviewed on 7/1/24 at 1:09 pm Staff D stated if she discovered a tenant had fallen, she would assess, take vitals, and call the nurse on-call for directions prior to assisting the tenant up off the floor. Record review on 6/27/24 revealed the Program's Resident Fall policy directed he following: General Lift Assist and Fall Guidelines: a.) If a tenant has fallen, staff must take the tenant's vitals and contact the Regional Nurse Manager or nurse on-call for directions prior to assisting the tenant up off the floor. When interviewed on 7/1/24 at 11:08 am, the Community Director stated Staff A and Staff B should have contacted the Regional Nurse Manager or nurse on-call before lifting Tenant C1 up off the floor. The Community Director stated the staff failed to follow the Program's policy when they responded to Tenant C1's fall on	A 150		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0284	A. BUILDING: _____ B. WING _____	C 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING WILLOW ASSISTED LIVING	601 DAWN AVENUE FREDERICKSBURG, IA 50630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 150	Continued From page 4 1/26/24. The Community Director stated all Program staff were re-trained on the fall policy on 2/14/24. 3. On 7/9/24 at 11:45 am, the Community Director confirmed both findings.	A 150		